



Placement Review Request Form

Area

Central

Campus LSSP submits the Central Placement Review (CPR) Request Form only after

1. consultation by an LSSP,
2. intervention by the Behavior Program Specialist, and
3. for students with autism, intervention by the Autism Support Team.

Student and School Information

Student Name: ID#: DOB: Age:
Home School: Current School: Grade:
Gender: Ethnicity: LEP Status: Home Language:
Homeless: Lives in RF: In CPS Custody:
Principal: Senior Manager: Program Specialist:
Disabilities: Current Placement: Current Instructional Code:
Number of Students in Class: Number of Teacher & Aide: Student is Verbal:
Days of Absences: Excused: Unexcused: Suspensions:
Previous Placement 1: Where? For how long? months
Previous Placement 2: Where? For how long? months
Previous Placement 3: Where? For how long? months
Curriculum: Standard Alternate Assessment: STAAR STAAR-Accommodated STAAR-ALT
Reason for Referral:

ARD/IEPs and Evaluations

Last Annual ARD/IEP: Current FIE Date: Last FBA Date:
BSIP Dates: (most current first) 1 2 3
Current BSIP Target Behaviors: 1 2
MDR Dates: (most current first) 1 2 3
Reasons for MDR:

Placement Review Dates: 1 2 3

Counseling and Psychological Services

Counseling Evaluation Date: Frequency: Duration: minutes

Psychological Services Evaluation Date: Frequency: Duration: minutes

Outside District Treatment: Where: By Whom:

Outside Treatment Goals:

Frequency: Duration: minutes for months

Parent Consent to Contact Outside Counselor/Therapist:

Social Work Services

School Social Worker Involved: School Social Worker Name:

Social Work Services Received:

Frequency: Duration: minutes for months

Outside Social Services Provider: Contact Number:

Parent Consent to Contact Outside Social Services Provider:

Hospital / Medical Information

Psychiatrist's Name: Contact Number:

Parent Consent to Contact Psychiatrist:

Physician's Name: Contact Number:

Parent Consent to Contact Physician:

Hospital Name: Contact Number:

Hospitalization Dates: from to ; from to

Hospital Name: Contact Number:

Hospitalization Dates: from to ; from to

Hospital Name: Contact Number:

Hospitalization Dates: from to ; from to

Parent Consent to Contact Hospital/Attending Physician:

Current Medications:

Behavior Specialist Intervention	
1	1. Initial assessment and baseline data collection.
2	2. Development of individualized behavior intervention plan (BIP).
3	3. Implementation of BIP with ongoing monitoring and data collection.
4	4. Regular communication and collaboration with the classroom teacher and other stakeholders.
5	5. Adjustment of BIP based on progress and changing needs.
6	6. Documentation of all interventions and progress.
7	7. Regular reporting to the IEP team and other relevant parties.
8	8. Ongoing professional development and training.
9	9. Collaboration with parents and guardians.
10	10. Evaluation of the effectiveness of the intervention.

Behavior Specialist Name: _____

Dates of Visit:	1	2	3	4	5
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Interventions Recommended:

Intervention Implementation Dates: from to

Results:

Autism Support Team Intervention (For Students with Autism)

Itinerant Autism Teacher-Name: _____

Dates of Visit:	1	2	3	4	5
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Interventions Recommended:

Intervention Implementation Dates: from to

Results:

LSSP Consultation	
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LSSP Name: _____ Parent Consent Date: _____

Intervention Dates: 1 2 3 4 5

Interventions Recommended:

Intervention Implementation Dates: from to

Results:

Behavior and Intervention History Continued (Completed by Campus Chairperson or case manager and reviewed by the LSSP)

Placement Review Committee Recommendations

Signatures

Participant's Name

Participant's Title

Date of Placement Review: